M-TAC
Medi-Cal Mobile Crisis Training and Technical Assistance Center

Tuchily Healing Hearts: Case Study and Reflection Tool

Introduction: Addressing Crisis Response Gaps in Tribal Communities

Tribal communities often experience critical gaps in crisis response when conventional county services are not culturally aligned or readily accessible. Many county-based mobile crisis teams strive to be inclusive, but few models fully integrate Tribal language, Native traditions, or the trust that comes with local relationships.

Tuchily Healing Hearts, created by the Pala Band of Mission Indians Social Services Department, was developed to address these gaps with a Tribally led, culturally informed mobile crisis response team. This approach ensures that Native families receive respectful, wraparound care in moments of crisis, while effectively engaging county partners and first responders.

Kauffman and Associates, Inc. and the Center for Applied Research Solutions have collaboratively documented this effort in a case study tool to guide other Tribes, counties, and mobile crisis teams interested in developing or strengthening Tribally driven crisis services.

Policy Highlights

*California recognizes **mobile crisis services** as a Medi-Cal benefit, and counties are required to implement mobile crisis teams and make them available 24/7 for behavioral health crises.[1] State guidance strongly encourages an integrated approach that serves all community members—including those experiencing mental health and substance use crises—under a coordinated system.[2] Notably, mobile crisis teams must coordinate with the 988 Suicide & Crisis Lifeline, local law enforcement, and other partners to ensure a swift response to crises and public awareness of these services.[3] This creates an opportunity for Tribes to partner with counties so that Tribal community needs are included in county crisis plans.*

[1] California Department of Health Care Services. (2023, June 19). *Medi-Cal mobile crisis services benefit implementation* (Behavioral Health Information Notice 23-025). https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf
[2] Ibid., 3.
[3] Ibid., 5.

1. Why a Tribal Mobile Crisis Team?

Tribal and urban Indian community members often hesitate to call county crisis lines because previous responses have felt unfamiliar, stigmatizing, or slow.

Tuchily Healing Hearts, a Tribal Mobile Crisis Response Team (TMCRT) created by the Pala Band of Mission Indians Social Services Department, demonstrates how a Tribally led, culturally rooted team can bridge that gap and still collaborate with external partners. “Tuchily” means “hummingbird” in Cupeño, evoking hope, resilience, and living language.[4]

The guiding idea is:

“Hurt people hurt people, but healed people heal people.” —Unknown

Reflective Questions:
Recognizing Gaps and Opportunities

- How well do current county crisis services serve your Tribal members and community? Are there gaps in accessibility or cultural alignment that leave your community vulnerable during crises?
- Do community members trust and use the existing county crisis lines or teams (e.g., 988 or 911)? What barriers (such as language, stigma, or past experiences) might prevent Native families from engaging with non-Tribal responders?
- If your community lacks its own crisis team, what are the most urgent needs that a Tribally tailored crisis response could address (e.g., youth suicide risk, substance-related crises, domestic violence situations)?

[4] Pala Band of Mission Indians Social Services. (2023). ***Tuchily Healing Hearts program overview.*** Crisis Care Mobile Units (CCMU) Learning Collaborative Tribal Mobile Crisis Services

2. Tuchily Team Operations

Depending on the situation, Tuchily Healing Hearts fields a **two-person crew**: a licensed clinician, a peer, community health worker (CHW), a caseworker or case manager, or other natural helper. A natural helper is a trusted community member who brings lived experience and cultural fluency. If additional support is needed, consultation would occur through the Social Services Director or the Tribal Chairman. Calls reach the team through a dedicated hotline or are transferred from 988, the county, 911, Tribal police, or family members.[5]

Workflow in Brief

1. **Call and Triage:** The TMCRT gathers safety information (about suicidality, weapons, and medical issues) and decides whether to dispatch the mobile unit or refer the caller elsewhere.
2. **Mobile Response:** An unmarked Sport Utility Vehicle (SUV) arrives within roughly 1 hour locally (longer for rural distances). The crew first ensures scene safety, then stabilizes the individual using trauma-informed, culturally appropriate approaches.
3. **Next Steps:** If a higher level of care is required, the team arranges transport to an appropriate referral site.
4. **Thirty-Day Follow-up:** Case managers and peers stay in contact—by phone, home visit, or escort to appointments—linking clients to therapy, community services, housing supports, or substance use treatment.

Thoughts for Consideration

- Who in your community already has the trust and skills to form a two-person crisis crew?
- What travel times and terrain would shape your own response time goals (e.g., 1 hour, 2 hours)?
- Which local facilities, including traditional healing and natural helping spaces, could provide the important post-crisis aftercare services needed for your community members?

Table 1 compares key elements of the Pala TMCRT model with questions that other Tribes or Indian Health Care Providers (IHCPs) can use to shape their own service design.

[5] Ibid.

Table 1. Elements of Current TMCRT Practice and Considerations for Your Tribe/IHCP

Element	Current TMCRT Practice	Consider for Medi-Cal Benefit Alignment
Staff Mix	Two-person crew: Licensed clinician, caseworker, or peer/CHW/natural helper; other resources available by phone.	Minimum 2 providers from [BHIN Table 1]: LPHA, peer specialists, SUD counselors, CHWs, Traditional Healers, EMTs and more. One team member may join via telehealth.
Activation	Phone referrals from self, family, Pala Fire Department, Tribal police, San Diego County 911, 988, or other agencies.[6]	Establish formal agreements with county for 988/crisis line and 911 dispatch integration. Document referral pathways ensuring AI/AN beneficiaries can access TMCRT.
Response Tiers	Goals: Reaching local areas in 1-hour, rural areas in 2 hours, and remote areas in 3 hours.	Response times are within 60 minutes for urban areas and120 minutes for rural areas.
On-Scene Steps	Visual safety check → brief assessment (including Patient Safety Screener [PSS-3]) → safety plan → transport if needed.	Use county-approved standardized screening/triage tool, comprehensive crisis assessment, safety planning documentation, and referral/linkage documentation per BHIN 23-025.
Follow-up	Minimum 30-day contact: Case management, referrals, transport, and family engagement.	72-hour follow-up check-in required to support continued crisis resolution, update safety plans, and verify referral connections. Follow-up may be conducted via phone/video by any trained team member. Extended follow-up permitted if medically necessary.
Funding	Crisis Care Mobile Unit (CCMU) grant and Tribal general fund; Medi-Cal billing pathway under exploration.	The benefit is administered by county behavioral health plans, which bill a bundled encounter rate — so IHCPs must coordinate or contract with counties to access that funding. To do this, Tribal health programs and FQHCs could establish a separate line of business as shared in SPA 22-0043 Tribal Notice.

[6] Ibid.

3. County Coordination and Billing

Although fully Tribally led, Tuchily Healing Hearts coordinates with county partners, law enforcement, emergency medical services (EMS), and regional hospitals when needed. Collaboration happens through relationally driven pathways, with more formal agreements under discussion.

- **Behavioral Health Information Notice (BHIN) 23-025:** This sets statewide mobile crisis standards to be eligible to bill under the Medi-Cal benefit.[7]
- **BHIN 23-027 and BHIN 22-053:** Counties **must** pay IHCPs for eligible behavioral health services (e.g., Drug Medi-Cal) at average industry rates (AIR) or a negotiated rate, even without a county contract.[8] [9]
- **Idea for TMCRTs:** Consider these notices when drafting memorandums of understanding (MOUs) or purchase-of-service agreements. Request written language that obligates the county to (1) accept your encounter documentation and (2) pay agreed rates for crisis visits involving American Indian or Alaska Native Medi-Cal members.

Thoughts for Consideration

- What Native words, symbols, or relational teachings best signal healing for your own community?
- How could these appear on vehicles, shirts, or flyers so that callers know the team is run "by us, for us?"

[7] California Department of Health Care Services. (2023, June 19). *Medi-Cal mobile crisis services benefit implementation* (Behavioral Health Information Notice 23-025). https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf

[8] California Department of Health Care Services. (2023, June 26). *Obligations related to Indian Health Care Providers in Drug Medi-Cal (DMC) counties* (Behavioral Health Information Notice 23-027). https://www.dhcs.ca.gov/Documents/BHIN-23-027-Obligations-Related-to-Indian-Health-Care-Providers-for-DMC-Counties.pdf

[9] California Department of Health Care Services. (2022, September 26). *Obligations related to Indian Health Care Providers in Drug Medi-Cal Organized Delivery System (DMC-ODS) counties* (Behavioral Health Information Notice 22-053). https://www.dhcs.ca.gov/Documents/BHIN-22-053-Obligations-Related-to-Indian-Health-Care-Providers-in-DMC-ODS-Counties.pdf

4. Building Blocks for a Tribal Mobile Crisis Plan

Pair each building block with information relevant to your community.

Thoughts for Consideration

- Does our Tribe/IHCP already bill Medi-Cal for clinic visits or substance use disorder services? If yes, who can help adapt encounter forms to mobile crisis codes?
- If we prefer a county subcontract, what audit scope and data-sharing limits protect sovereignty while allowing payment?
- Which county contact, such as a behavioral health chief financial officer or 988 coordinator, can co-design a claims workflow that does **not** force full provider enrollment?
- Which county officials, such as a behavioral health director, sheriff, EMS chief, can champion a partnership conversation?
- What specific points should an MOU cover (e.g., dispatch triggers, data-sharing safeguards, training exchanges, liability during transport)?
- Would your Tribe prefer to bill Medi-Cal directly through the AIR or to invoice the county for each crisis? What staffing, documentation, and audit protections would each path require?

Table 2 introduces the core building blocks of the Tuchily model and offers prompts for IHCPs to adapt each element to their own mobile crisis plans.

Table 2. Building Blocks for a Tribal Mobile Crisis Plan

Building Block	Tuchily Insight	Considerations for Your Community
Community-Based Staffing	Local hires, establishing instant trust and cultural fluency	Who in our community (peers, Indian Child Welfare Act workers, cultural mentors) could fill crisis roles with added training?
Cultural Safety	Cupeño name, elder input, training for external responders	Which traditions or Native-language greetings would calm people in distress without seeming tokenistic?
Dispatch Links	Calls accepted from assigned crisis line, San Diego Sheriff's Department, and or Tribal Law Enforcement	Which technology or MOU would allow county dispatch to "flag" Tribal addresses for dual-tone?
Vehicle and Gear	Unmarked SUV, personal protective equipment, blankets, tablets, comfort items	What budget and specifications are needed for safe transport in our terrain?
Post-Crisis Wrap	Structured 30-day follow-up; warm handoffs to clinic	Which program (Tribal Behavioral Health, Indian Health Service, county services) will track re-engagement and outcomes?
Sustainability	Grants now; exploring Medi-Cal paths	How do Tribal AIR encounter rates factor into mobile crisis services, county fees, or a hybrid model? What data supports value for your service?

5. Sustaining the Work and Mini Readiness Checklist

Tuchily Healing Hearts currently uses CCMU grant dollars augmented by the Tribe's general fund. The team is now exploring how to map its service documentation to Medi-Cal mobile crisis codes in partnership with local IHCPs so that visits may become reimbursable. Though each Tribe's fiscal landscape is different, a blended funding plan, **using start-up grants while billing pathways mature**, offers a route forward.

If your Tribe is considering launching a (TMCRT), here are a few key factors to keep in mind:

Quick Readiness Checklist

1.	**Endorsement:** Tribal council or board resolution supports a culturally specific crisis team.
2.	**Core Crew:** At least one clinician and one peer/CHW is identified for on-call rotations. Does your community currently operate an IHCP?
3.	**Dispatch Plan:** Single phone number is chosen; initial protocol has been drafted with county 911/988.
4.	**Training Calendar:** Training on de-escalation, suicide intervention, trauma-informed care, and other required core and enhanced training sessions are available through the Medi-Cal Mobile Crisis Training and Technical Assistance Center (M-TAC).
5.	**Funding Map:** Bridge grants have been explored or secured; discussions have commenced with county fiscal leads on Medi-Cal billing.
6.	**Community Outreach:** Flyers, social media content strategy, or school visits are used to normalize help-seeking and team introductions—or begin gathering community feedback to guide your planning process.

Closing Thoughts

Tuchily Healing Hearts illustrates that a Tribal nation can lead crisis response that is swift, culturally safe, and effective—without surrendering autonomy. Apply the elements shared in this tool to identify your own community's unique needs, then consider crafting agreements and workflow processes that heal hearts on your community's terms. For additional information or to request no-cost technical assistance and training to support your Tribal mobile crisis response team, please visit us at the M-TAC home page.

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Your vision, steadfast advocacy, and hands-on leadership light the way for Tribal mobile crisis innovation across California and beyond. By demonstrating how community-driven response can save lives and restore hope, you inspire us all to pursue crisis systems that honor Tribal autonomy, sovereignty, language, and healing.